Utah's Job Connection

Employer's Health Insurance Information

Date Received

Case #: _____

☐ This form MUST be completed by your employer or your company's Human Resources representative. Any blanks left on this form may delay the process.

☐ A form must be completed for each employed household member.

1 General Information

Employee Name : _____ SSN: _____

Company Name: _____ EIN: _____

☐Yes ☐No A. Does your company offer health insurance? If no, skip to section 4. Sign and return the form.

☐Yes ☐No B. Is the employee eligible to enroll in any insurance plan offered?
If no, please explain: _____
If yes, when is/was the employee eligible to enroll? (mm/dd/yy) _____

☐Yes ☐No C. Is the employee or any family member enrolled in any insurance plan offered?
If yes, name(s) of persons enrolled: _____
_____
_____

☐Yes ☐No D. Has this employee or any family member dropped/changed coverage in the last six months?
If yes, name(s): _____
If yes, when did coverage end/change? (mm/dd/yy) _____

2 Least Expensive Plan

Questions below refer to the ***least expensive*** plan offered at your company.

☐Yes ☐No A. Does the employee have to enroll in order to add their dependent(s)?

B. When will/did coverage begin? (mm/dd/yy) _____

C. When does the company's next open enrollment begin? (mm/dd/yy) _____

D. Complete the chart below. **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	$	$
Employee + spouse	$	
Employee + child	$	
Family	$	

E. Please list the yearly health plan deductible (not the "out of pocket" cost or hospital deductible).
Individual amount $_____ Family amount $_____

☐Yes ☐No F. Does the plan pay for any services (doctor, pharmacy, etc.) before the employee has met the deductible listed above?

(continued)

3 Employee's Health Plan Choice

Questions below refer to the plan the employee has selected. Questions B-G refer to "in-network" benefits.

A. Insurance company and plan name: _____

☐Yes ☐No B. Is the deductible $1000 or less per individual?

☐Yes ☐No C. Does the plan pay at least 70% of an inpatient stay (after the deductible)?

☐Yes ☐No D. Is the lifetime maximum benefit $1,000,000 or more?

E. What benefits are covered under this plan? (Check all that apply.)

☐ Physician visits ☐ Hospital inpatient services ☐ Pharmacy/Rx
☐ Well child exams ☐ Child immunizations

F. Complete this chart only if it is different from the chart on the front page (section 2). **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	$	$
Employee + spouse	$	
Employee + child	$	
Family	$	

☐Yes ☐No G. Are the employee's children currently enrolled or do they plan to enroll in your company's dental plan? If yes, name(s):_____

4 Signature

I certify that I am a representative of the Human Resource Department, or that I am the health insurance contact person. The information on this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Name (please print): _____

Title: _____ Phone: _____

Please return completed form to:

DWS/CIU
PO Box 143245
SLC, UT 84114-3245
Fax: 801-526-9500